DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/26/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01, 03, 04 B. WING		(X3) DATE SURVEY COMPLETED R 07/21/2011			
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME				1900	T ADDRESS, CITY, STATE, ZIP CODE RANDALLIA DRIVE RT WAYNE, IN 46805		07/21/2011		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
{K 000}	and a Post Survey Safety Code Recer Survey conducted of the Indiana State Diaccordance with 42 Survey Date: 07/2 Facility Number: 0 Provider Number: AIM Number: 1002 At this FSES surve in compliance with Association) 101A, Evaluation System in regard to the PS Recertification and Achieving a passinfor Health Care Oc of NFPA 101A, Alte Safety, 2001 Editio level of Life Safety prescribed by NFP. The original buildin building and the masurveyed with Chap Occupancies. The original buildin story building of Ty basement. The magnestory fully spring construction and the physical therapy gy	uation System (FSES) Survey Revisit (PSR) to the Life tification and State Licensure on 06/22/11 was conducted by repartment of Health in 2 CFR 483.70(a). 1/11 00240 155349	{K (000}					
ABORATORY		R/SUPPLIER REPRESENTATIVE'S SIGNATURE	<u> </u>		TITLE		(X6) DATE		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155349		, ,	(X2) MI A. BUIL		CONSTRUCTION 01,03,04	(X3) DATE SURVEY COMPLETED		
		155349	B. WIN	G		R 07/24/2044		
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME				O7/21/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1900 RANDALLIA DRIVE FORT WAYNE, IN 46805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		SHOULD BE COMPLETION		
{K 000}	The facility has a fire detection in the corrid corridors. The facility had a census of 147 and Quality Review by Ro	alarm system with smoke lors and areas open to the has a capacity of 168 and at the time of this survey. bert Booher, Life Safety	{K C	000}				
{K 000}	A Fire Safety Evaluat and a Post Survey Re Safety Code Recertifi Survey conducted on the Indiana State Depaccordance with 42 C Survey Date: 07/21/1 Facility Number: 000 Provider Number: 15 AIM Number: 100274 At this FSES survey, in compliance with NE Association) 101A, Cl Evaluation System for in regard to the PSR Recertification and St Achieving a passing s for Health Care Occur of NFPA 101A, Altern Safety, 2001 Edition, level of Life Safety at prescribed by NFPA 1 The Rehabilitation un	cion System (FSES) Survey exisit (PSR) to the Life cation and State Licensure 06/22/11 was conducted by partment of Health in FR 483.70(a).	{K 0	000}				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1` ′		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
			A. BUI	LDING	01,03,04		
		155349	B. WING			07/21/2011	
NAME OF PROVIDER OR SUPPLIER SAINT ANNE HOME				19	REET ADDRESS, CITY, STATE, ZIP CODE 900 RANDALLIA DRIVE FORT WAYNE, IN 46805		
(X4) ID PREFIX				. ' іх	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION
TAG	REGULATORY OR L	REGULATORY OR LSC IDENTIFYING INFORMATION)			CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
{K 000}	story building with a beconstruction. The made one story fully spring (111) construction, and a physical therapy gas sprinklered building on The facility has a fire detection in the corridors. The facility	s a fully sprinklered three pasement of Type II (222) ain entrance/dining room is klered building of Type V d the Rehabilitation unit with	{K (000}			